Hoosier Care Connect
Frequently Asked Questions

Contents

Overview of Program

Q1. What is Hoosier Care Connect?

A. Hoosier Care Connect is a coordinated care program for Indiana Health Coverage Programs (IHCP) members age 65 and over, or with blindness or a disability who are residing in the community and are not eligible for Medicare. Members select a managed care entity (MCE) responsible for coordinating care with medical provider(s). Hoosier Care Connect members receive all Medicaid-covered benefits in addition to care coordination services. Care coordination services are individualized based on a member's assessed level of need determined through a health screening.

Q2. What is a managed care entity (MCE)?

A. An MCE is a health plan that contracts with the Indiana Family and Social Services Administration (FSSA) to deliver covered services to Hoosier Care Connect members. MCEs receive a per-member, per-month payment and are at financial risk for all services included in the contract. The MCE develops a network of physicians and other providers who provide healthcare services to members and reimburse claims for services rendered. Through FSSA's contract, MCEs are held accountable for achieving metrics related to outcomes, process, quality and satisfaction and are given financial incentives tied to achievement of performance metrics.

Q3. Which MCEs have contracts for Hoosier Care Connect?

A. The State has awarded contracts to Anthem and Managed Health Services (MHS). These MCEs were chosen through a fair and open procurement process managed by the Indiana Department of Administration and FSSA. MCEs were chosen based on their responses to a Request for Proposals (RFP) posted in the summer of 2014. Prospective vendors were assessed based on many factors, including their experience serving complex populations and approaches to care management.

Q4. What are the goals of Hoosier Care Connect?

A. In developing Hoosier Care Connect, FSSA seeks to achieve the following goals for Indiana Health Coverage Programs' aged, blind, and disabled members:

- Improve quality of care and health outcomes
- Ensure consistency of care across the healthcare delivery system
- Ensure member choice, protections and access
- Coordinate care across the healthcare delivery system and care continuum
- Provide flexible person-centered care
- Promote preventive and holistic care addressing physical, behavioral, medical and social needs
- Increase consumer engagement in the management and treatment of member conditions

Q5. How was the Hoosier Care Connect program created?

A. House Enrolled Act 1328 (HEA 1328-2013) passed by the Indiana General Assembly in 2013 tasked FSSA with submission of a report to the Health Finance Committee regarding options for managing care for Indiana Medicaid's aged, blind and disabled population. In response to HEA 1328, FSSA convened the Aged, Blind and Disabled Task Force (Task Force). The Task Force undertook a comprehensive analysis of current Indiana Medicaid enrollment, expenditures and programming. Additionally, it reviewed nationwide trends and Medicaid managed care strategies available for disabled populations.

Throughout this process, stakeholder feedback was garnered through a variety of strategies. Stakeholders were invited to provide proposals or ideas to the Task Force. Additionally, a stakeholder survey was developed and distributed with a total of 143 surveys returned representing providers, consumers, advocates and other stakeholders. The process undertaken by the Task Force, lessons learned, and goals garnered through stakeholder feedback, laid the foundation for development of the Hoosier Care Connect program.

Eligibility Criteria & Covered Benefits

Q6. Who is eligible for Hoosier Care Connect?

A. Hoosier Care Connect is for IHCP members age 65 and over, or with blindness or a disability who are residing in the community. Individuals enrolled in Medicare, and those residing in an institution or receiving services through a home and community-based services (HCBS) waiver, are not eligible for Hoosier Care Connect. Individuals in the following eligibility categories who do not have an institutional level of care and are not enrolled in Medicare will be enrolled in Hoosier Care Connect:

- Aged individuals
- Blind individuals
- Disabled individuals
- Individuals receiving Supplemental Security Income
- M.E.D. Works members

Children who are wards of the State, receiving adoption assistance, foster children and former foster children may also choose to enroll in the program.

Q7. How many people are covered under Hoosier Care Connect?

A. Current enrollment levels average approximately 94,000 individuals in any given month.

Q8. What benefits are covered under Hoosier Care Connect?

A. Hoosier Care Connect members receive all Medicaid-covered benefits in addition to care coordination services and other enhanced benefits offered by MCEs and approved by FSSA. Hoosier Care Connect MCEs are responsible for the majority of covered services including primary care, acute care, prescription drugs and certain over-the-counter drugs, behavioral health, emergency services, dental and transportation. MCEs are not financially responsible for some services, referred to as “carve-outs.” The Hoosier Care Connect carve-outs include Medicaid Rehabilitation Option (MRO) services, 1915(i) State Plan home and community-based services, as well as First Steps and individualized education plan services. While MCEs are not financially responsible for carved-out services, they must ensure coordination of all Medicaid-covered services and implement strategies to prevent duplication and fragmentation of care across the healthcare delivery system.

Q9. What members are excluded from Hoosier Care Connect?

A. Individuals are removed from the Hoosier Care Connect program and transitioned to Traditional Medicaid if they enter a nursing home for a stay longer than 30 days, enter a state psychiatric facility, psychiatric residential treatment facility (PRTF) or intermediate care facility for individuals with

intellectual disabilities (ICF/IID), begin receiving hospice benefits in an institutional setting, or become eligible for an HCBS waiver or Medicare.

Provider Questions

Q10. What action is needed by IHCP providers?

A. FSSA strongly encourages providers to consider joining an MCE network. Once MCEs have demonstrated they have a sufficient number of providers to serve their members they are permitted to require members to utilize in-network providers. Providers may participate in more than one MCE network. Please contact the Hoosier Care Connect MCEs to learn more about joining the network. Contact information can be found on the IHCP Quick Reference Guide (QRG) on the provider site at indianamedicaid.com.

Q11. How do providers verify that a patient is enrolled in Hoosier Care Connect?

A. Providers verify member eligibility using existing IHCP Eligibility Verification Systems (EVS). The EVS identifies the following information for members in Hoosier Care Connect:

- The member is eligible for "Full Medicaid" coverage
- The member's assigned MCE and the corresponding MCE contact information
- The member's primary medical provider (PMP) (Note: Until a member has selected a PMP or been assigned to one, this field will display "PMP not available")

MCEs issue ID cards to their enrolled members which identifies the member's IHCP Member ID or RID number.

Q12. Do the MCEs develop their own preferred drug lists (PDL)?

A. MCEs are responsible for the delivery of pharmacy benefits and for developing their own preferred drug lists (PDL). The MCEs' PDLs are posted on their websites for provider reference.

Q13. Are there any covered services providers do not bill to the Hoosier Care Connect MCEs?

A. MCEs are not financially responsible for some services, referred to as "carve-outs." MCEs do not reimburse claims for Medicaid Rehabilitation Option (MRO) services, 1915(i) State Plan home and community-based services, and First Steps and individualized education plan services. Providers bill the IHCP instead of the MCEs for these "carved-out" services.

Member Questions

Q14. How do I apply for Hoosier Care Connect?

A. You do not specifically apply for Hoosier Care Connect. You apply for Medicaid and if you are determined to be income eligible and are aged, blind or disabled, don't reside in an institution, do not receive Medicare, and are not eligible for home and community-based services (HCBS) waiver services,

you will be eligible for Hoosier Care Connect. You will receive a letter from the Indiana Family and Social Services Administration (FSSA) telling you if you are eligible for Hoosier Care Connect.

Q15. What is different between Hoosier Care Connect and Traditional Medicaid?

A. In Hoosier Care Connect you enroll with a health plan that provides most of your Medicaid-covered benefits. A health plan, also called a managed care entity (MCE), is a group of doctors, pharmacies and hospitals that work together to help you get the healthcare services you need. You can choose one of the following two health plans: Anthem and MHS. All plans offer the same services but may work with different doctors or hospitals and may offer special programs that you would like. Your health plan also offers special services such as a 24-hour nurse helpline and care coordination services based on your needs.

Q16. Can I go to any doctor as long as they accept Hoosier Care Connect or Medicaid?

A. Once you are enrolled with a health plan you will choose a primary medical provider (PMP). Your health plan will contact you to tell you what you need to do to select a PMP. Once you have selected a PMP you will see that doctor for most of your healthcare services. Your PMP will help you access other doctors that you need for any special healthcare needs you have. You can get the following healthcare services without a referral from your health plan or PMP:

- Behavioral health services
- Chiropractic services
- Diabetes self-management services
- Emergency services
- Family planning services
- Immunizations
- Podiatry
- Psychiatric services
- Vision

Q17. Can I change my primary medical provider (PMP) after I choose one?

A. You can change your PMP by calling your health plan.

Q18. What should I consider when choosing a health plan?

A. Choosing a health plan is a personal decision. While FSSA is confident that all health plans are able to meet your needs, you may want to consider the following points when choosing a health plan:

- Doctor: If you already have a favorite doctor that you want to continue to see, you can call the Hoosier Care Connect Helpline at 1-866-963-7383 to find out if your doctor participates in one or more of the health plans.
- Locations: You may want to make sure that the health plan has providers that are conveniently located for you. This may mean they are near your home, your work, your child's school, or on a bus line. You can call the Hoosier Care Connect Helpline at 1-866-963-7383 to find out what doctors are located near you in each health plan.
- Special Programs: Hoosier Care Connect health plans each offer special programs such as disease management and wellness programs. You may want to select the health plan that offers special programs for something that is of interest to you. You can call the Hoosier CareConnect

Helpline at 1-866-963-7383 to learn more about the special programs offered by each health plan.

Q19. How do I select a health plan?

A. To make your health plan selection, please call the Hoosier Care Connect Helpline at 1-866-963-7383.

Q20. What happens if I don't choose a health plan?

A. If you do not choose a health plan within sixty days of enrollment, you will be assigned one. It is better if you choose an MCE so you can go to a doctor's office that you know and who knows your history. Please contact the Hoosier Care Connect Helpline at 1-866-963-7383 to make your selection.

Q21. Can I change health plans after I make a selection?

You can change your health plan at certain times during the year:

- Any time during your first 90 days with a new health plan.
- Annually during your open enrollment period.
- If you file a grievance with your health plan, and the State finds that you have a good reason to change health plans. Another name for a good reason to change health plans is "just cause." You must first contact your health plan so they can attempt to resolve your concern. If after contacting your health plan you are still not satisfied, you can call the Hoosier Care Connect Helpline at 1-866-963-7383, and they will review your request.
- If your primary medical provider (PMP) changes health plans, you can follow your PMP to the new health plan.

Q22. What can I expect after I choose a health plan?

A. You will receive an enrollment packet from your health plan after you make your selection. This enrollment packet will include a member identification card that you should carry with you at all times. You must show the member identification card to your doctor, hospital and pharmacy whenever you get services. The enrollment packet will also give you more information about Hoosier Care Connect, your health plan and how to access services. Your health plan will also do a health screening to learn about any special healthcare needs you may have. It is very important you complete the health screening so you can receive special services based on your needs.

Q23. Are there any reasons I would be removed from Hoosier Care Connect?

A. You will transition to Traditional Medicaid if you enter a nursing home for longer than 30 days, or enter a state psychiatric facility, psychiatric residential treatment facility (PRTF) or intermediate care facility for individuals with intellectual disabilities (ICF/IID). You will also be transitioned to another Medicaid program if you begin receiving hospice benefits in an institutional setting, become eligible for home and community-based services through a Medicaid waiver program or enroll in Medicare.

Q24. What if I disagree with a decision made by my health plan?

A. If you disagree with a decision made by your Hoosier Care Connect health plan you can file an appeal with them. If you are not satisfied with the outcome of that appeal you can file an appeal with the State. You will receive a written notice from your health plan with instructions on how to appeal anytime they make a decision about your care or benefits. The member handbook you receive from your health plan will also give you instructions on how to file an appeal.